

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>39X0009872</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>02/12/2023</b>
NAME OF PROVIDER OR SUPPLIER: <b>PDI HEALTH PA, LLC</b>  STATE LICENSE NUMBER: <b>N6990701</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2929 ARCH ST, STE 1712 PHILADELPHIA, PA 19104</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
H 0000	<p>INITIAL COMMENT</p> <p>This report is the result of a revisit survey conducted on February 13, 2023, as a result of a full Medicare recertification survey conducted on November 14-15, 2022, at PDI Health PA, LLC. It was determined that the facility was in compliance with the requirements of 42 CFR, Title 42, Part 486 - Conditions of Participation for a Portable X-ray Provider.</p>	H 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



# Certified End Page

**PDI HEALTH PA, LLC**

**STATE LICENSE NUMBER: N6990707**

**SURVEY EXIT DATE: 02/12/2023**

**I Certify This Document to be a True and Correct Statement of Deficiencies and  
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

*Jeane Parisi*  
*Deputy Secretary for Quality Assurance*

A handwritten signature in black ink that reads "Debra L. Bogen MD".

*Debra L. Bogen, MD, FAAP*  
*Acting Secretary of Health*



THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY